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07/93 d. Non Hospital-Based Clinic Reimbursement

i. County-Operated Outpatient Facility Reimbursement

09/97 For those encounter rate hospitals described as Illinois county-operated outpatient facilities in a county with a population exceeding 3 million that do not qualify as either a Maternal and Child Health Program managed care clinic, or as a Critical Clinic Provider, as described in subsection e. below, reimbursement for all services provided by county-operated outpatient facilities shall be reimbursed on an all-inclusive per encounter rate basis as follows:

A. Base Rate

The per encounter base rate shall be calculated as follows:

1. allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.

07/95 2. The resulting quotient, as calculated in 1. above shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.

3. The resulting product as calculated in 2. above shall be added to the resulting quotient, as calculated in 1. above to determine the per encounter base rate.

07/95 B. Supplemental Rate

1. The supplemental service cost shall be divided by the total number of direct staff encounters to determine the direct supplemental service cost per encounter.

07/95 2. The direct supplemental service cost, as calculated in 1. above, shall be multiplied by the Medicare allowable overhead rate factor to calculate the supplemental overhead cost per encounter.

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07/95 3. The resulting product, as described in 2. shall be the per encounter supplemental rate.

C. Final Rate

07/95 1. The per encounter base rate, as described in d.i..A. shall be added to the per encounter supplemental rate as calculated in d.i.B. to determine the per encounter final rate.

07/95 2. The per encounter final rate shall be adjusted in accordance with D. below.

D. Rate Adjustments

07/95 Adjustments to the per encounter final rate as derived in C. above shall be calculated as follows:

07/98 1. Effective October 1, 1992, the final reimbursement rates described in C. above shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992, and on the first day of July of each year thereafter, by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. Effective July 1, 1998, the final rate shall be no less than $147.09 per encounter.

2. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

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ii. County-operated outpatient facilities shall be required to submit outpatient cost reports to the Department within 90 days of the close of the facility's fiscal year. No year-end reconciliation for outpatient and clinic services is made to the reimbursement calculated under this section.

iii. Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located.

09/97 e. Critical Clinic Providers

i. Effective for services provided on or after September 27, 1997, clinics owned and operated by a county with a population of over three million, that are within or adjacent to a hospital, shall qualify as a Critical Clinic Provider if the facility meets the efficiency standards established by the Department. The Department's efficiency standards under this subsection .e. requires that the quotient of total encounters per facility fiscal year for the Critical Clinic Provider divided by total full time equivalent physicians providing services at the Critical Clinic Provider shall be greater than:

A. 2700 for reimbursement provided during the facility's cost reporting year ending during 1998,

B. 2900 for reimbursement provided during the facility's cost reporting year ending during 1999,

C. 3100 for reimbursement provided during the facility's cost reporting year ending during 2000,

D. 3600 for reimbursement provided during the facility's cost reporting year ending during 2001,

E. 4200 for reimbursement provided during the facility's cost reporting year ending during 2002,

ii. Reimbursement for all services provided by a Critical Clinic Provider shall be on an all-inclusive per encounter rate which shall equal reported direct costs of the Critical Clinic Provider for the facility's cost reporting period ending in 1995, divided by the number of Medicaid services provided during that cost reporting period as adjudicated by the Department through July 31, 1997.

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09/97 iii. Critical Clinic Providers, as described in this subsection .e., shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection .e..

iv. The reimbursement rates described in this subsection .e. shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

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07/98 ~~e~~f. Special Reimbursement Requirements for Services Provided in Hospital Emergency Room and Clinic Settings.

i. When emergency room services are provided to clients, the hospital is required to code any fee-for-service claims with the emergency room place of service.

07/98 ~~f~~g. Encounter rate clinic reimbursement

07/98 i. ~~Reimbursement is the lower of the clinic's charge to the general public, the per visit rate established by the Department as of May 1, 1981, or the maximum statewide clinic rate established by the Department. Payment limitations in this paragraph shall not consider transitional payments under Attachment 4.19-B.h.. Payment limitations in this paragraph shall not consider transitional payments under Attachment 4.19-B.h.. The rate is not reconciled or reimbursed on a basis of costs.~~ For encounter rate clinics providing comprehensive health care for women and infants or encounter rate clinics operated by a county with a population of over three million, payment shall be made at the lesser of:

07/98 A. $50.00 per encounter; or

07/98 B. The clinic charge to the general public.

07/98 ii. For all other encounter rate clinics, payment shall be made at the lesser of:

07/98 A. The clinic's approved all inclusive interim per encounter rate as of May 1, 1981; or

07/98 B. $50.00 per encounter; or

07/98 C. The clinic charge to the general public.

07/98 g~~h~~ Psychiatric clinic reimbursement

Reimbursement shall be made under the federally qualified health center methodology if the clinic meets the criteria as an FQHC. Otherwise the clinic shall be reimbursed as an encounter rate clinic.

07/98 h~~i~~. Transitional Payments for FQHCs and Certain Encounter Rate Clinics

i. Certain clinics will be eligible to receive monthly transitional payments for managing the health care needs of certain clients under their care beginning December 1996. Certain clinics will be

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eligible to receive transitional payments for the month of December 1996, and monthly thereafter, under the conditions described in this subsection. To receive monthly transitional payments, clinics must:

A. be either:

1. a Federally Qualified Health Center, as defined in Attachment 4.19-B.2.a. or

2. an Encounter Rate Clinic, as defined in Attachment 3.1-A.2..b., that has provided comprehensive health services to Medicaid clients prior to December 1996;

B. have a signed transitional payment contract with the Department; and

C. have a contract with a Health Maintenance Organization (HMO) or Prepaid Health Plan (PHP) that has a contract to provide comprehensive health services, or, upon the implementation of MediPlan Plus, have a contract with a Managed Care Entity (MCE). The fee-for-service equivalent of the sum of such contract, and any transitional payment described in this Attachment, may not exceed the limits described in Attachment 4.19-B.1.g.1. or Attachment 4.19-B.2.a.iv.

ii. Transitional payments to a clinic will consist of a per member per month payment for any Illinois Medicaid client enrolled with an HMO or PHP or, upon the implementation of MediPlan Plus, an MCE, for whom the clinic was their assigned care provider on the last day of the month.

iii. For the first six months covered under a transitional payment contract, the Department will make transitional payments for any number of Medicaid clients enrolled with an HMO, PHP or MCCN and assigned to the qualifying clinic as their primary care site. Thereafter, qualified clinics will receive transitional payments for a given month only if the total number of Medicaid clients enrolled with an HMO, PHP or MCCN and assigned to the qualifying clinic, meets or exceeds the following threshold levels established in the qualifying clinic's transitional payment contract for that month:

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A. For the seventh through twelfth month, such threshold shall equal twenty percent(20~~%~~) of the qualifying clinic's Medicaid patient base;

B. For the thirteenth through eighteenth month, such threshold shall equal thirty percent (30%) of the qualifying clinic's Medicaid patient base;

C. For the nineteenth through twenty-fourth month, such threshold shall equal forty percent (40%) of the qualifying clinic's Medicaid patient base;

D. For the twenty-fifth month through the term of the contract, such threshold shall equal fifty percent (50%) of the qualifying clinic's Medicaid patient base.

iv. The Medicaid patient base shall be a number mutually agreed to by the Department and the qualifying clinic and established in the transitional payment contract that equals the number of Medicaid clients registered as patients of the qualifying clinic as of November 1996.

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v. Transition payments shall equal:

A. eight dollars ($8) per member per month for the first twelve (12) month period of the clinic's effective date of a contract with the Department;

B. six dollars ($6) per member per month for the second twelve (12) month period of the clinic's effective date of a contract with the Department;

C. two dollars ($2) per member per month for the third twelve (12) month period of the clinic's effective date of a contract with the Department.

vi. No clinic qualifying under this subsection shall receive transitional payments beyond the earlier of:

A. three years from the effective date of a clinic's signed contract, or

B. June 30, 2000.

ii. Pediatric Outpatient Adjustment Payments

07/98 Pediatric Outpatient Adjustment Payments shall be made to all eligible hospitals excluding county-owned hospitals and hospitals organized under the University of Illinois Hospital Act, as described in Section c.8. of Chapter II, for outpatient services occurring on or after July 1, 1998 ~~1997~~, in accordance with this Section.

i. To qualify for payments under this Section, a hospital must:

A. be a children's hospital, as defined in 89 Ill. Adm. Code Section c.3.of Chapter II and,

B. have a Pediatric Medicaid Outpatient Percentage greater than 80% during the Pediatric Outpatient Adjustment Base Period.

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ii. Hospitals qualifying under this Section shall receive the following amounts for the Pediatric Outpatient Adjustment Rate Year:

A. For hospitals with a Medicaid Inpatient Utilization Rate (MIUR) that is less than 75% during the Pediatric Outpatient Adjustment Base Period, the product of;

1. the hospital's MIUR plus one, multiplied by,

2. the number of Pediatric Adjustable Outpatient Services, multiplied by

07/98 3. $185 ~~70~~.

B. For hospitals with an MIUR that is greater than 75% during the Pediatric Outpatient Adjustment Base Period, the product of;

07/98 1. the hospital's MIUR plus one and one-half, multiplied by,

2. the number of Pediatric Adjustable Outpatient Services, multiplied by

07/98 3. $185 ~~70~~.

07/98 iii In addition to the reimbursement rates described in subsection ii. above, hospitals that have an MIUR that is greater than 80% during the Pediatric Outpatient Adjustment Base Period shall receive and additional $250,000 ~~500,000~~ during the Pediatric Outpatient Adjustment Rate Year.

iv. Adjustments under this Section shall be paid on a quarterly basis.

v. Definitions

A. "Medicaid Inpatient Utilization Rate (MIUR)," as used in this Section, has the meaning as defined in

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Section C.8.c., Chapter VI, or Attachment 4.19-A.

B. "Pediatric Adjustable Outpatient Services" means the number of outpatient services, excluding procedure code 0080, adjudicated through a UB92 billing form and grouped through the Hospital Ambulatory Care Groupings, as defined in Section 148.140.b..1., during the Pediatric Outpatient Adjustment Base Period. For a hospital,which includes a facility devoted exclusively to caring for children, that is separately licensed as a hospital by a municipality, Pediatric Adjustment Outpatient Services will include psychiatric services (categories of service 27 or 28) for children less than 18 years of age, that are billed through the affiliated general care hospital.

C. "Pediatric Medicaid Outpatient Percentage" means a percentage that results from the quotient of the total Pediatric Adjustable Outpatient Services for persons less than 18 years of age divided by the total Pediatric Adjustable Outpatient Services for all persons, during the Pediatric Outpatient Adjustment Base Year.

D. "Pediatric Outpatient Adjustment Base Period" means all services billed to the Department, excluding procedure code 0080, with Fiscal Year 1996 dates of services that were adjudicated by the Department on or before March 31, 1997.

E. "Pediatric Outpatient Adjustment Rate Year" means State Fiscal Year 1998 and each State Fiscal Year hereafter.

07/98 jk. Appeals for Pediatric Outpatient Adjustment Payments.

The Department shall make Pediatric Outpatient Adjustment payments in accordance with ~~Section 148.297.~~Section 1.j. above. Hospitals shall be notified in writing of the results of the determination and calculation, and shall have the right to appeal the calculation or their ineligibility for